ACGME Focus on Physician Well-Being : *Deepening our Commitment to Faculty, Residents, and Patients*

Timothy P. Brigham, M. Div., Ph.D.

ACGME

Disclosure

- Chief of Staff and Senior Vice President, Education, ACGME
- Associate Professor of Medicine, Jefferson Medical College *(volunteer)*
- Senior Scholar, Department of Medical Education, University of Illinois at Chicago College of Medicine
- No conflicts of interest to report
- The ACGME receives no funds from any corporate entity other than accreditation fees related to ACGME accreditation services
- The Journal of Graduate Medical Education permits only advertizing of classified position in academic institutions
- The ACGME Annual Educational Conference is entirely self sufficient, has no external sponsors, advertisers, or displays, and uses no accreditation fee revenue for support
- ACGME International is a Not-for-Profit entity

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Our Mission

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“We improve health care and population health by assessing and advancing the quality of resident physicians' education through accreditation. ”

ACGME Mission Statement

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MASTERY

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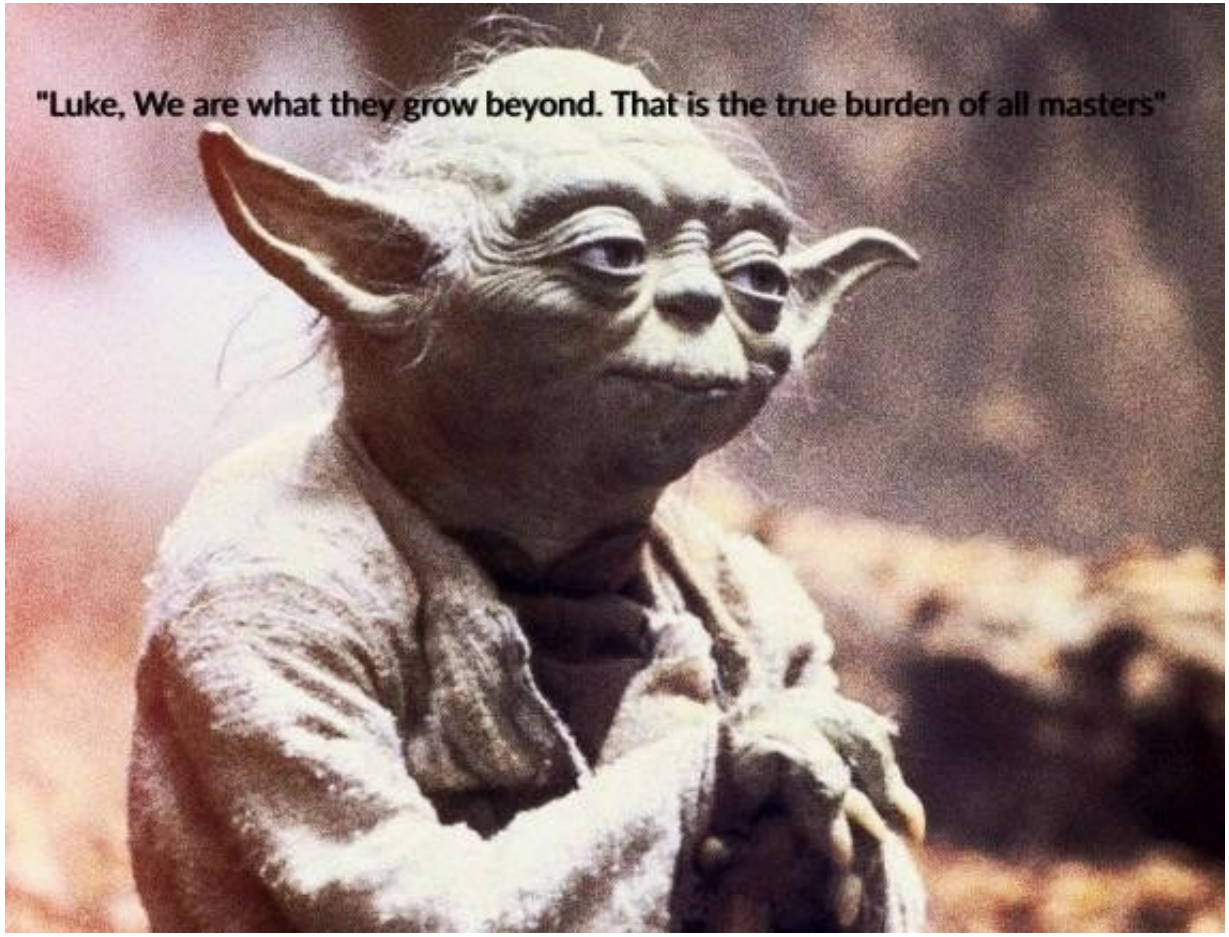
"Luke, We are what they grow beyond. That is the true burden of all masters"

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We are what they grow beyond. That is the true burden of all Masters.”

joy

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Well-being

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ACGME's Four Philosophical Pillars

- Excellence in the safety and quality of care rendered to patients by residents today
- Excellence in the safety and quality of care rendered to patients by today's residents in their future practice
- Excellence in professionalism through faculty modeling of:
  - The effacement of self-interest in a humanistic environment that supports the professional development of physicians
  - The joy in curiosity, problem-solving, intellectual rigor, and discovery
- Commitment to the well-being of the residents, faculty members, students, and all members of the health care team

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Patient Care and Physician Well-Being

- Clinicians who care for themselves provide better care for others
- They are less likely to make errors or leave the profession
- Habits of practice to promote well-being and resilience need to be cultivated across the continuum
- A healthy learning environment will lead to improved health care for all, both providers and patients

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What happens? (sometimes)

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Personality Characteristics

- Obsessive compulsive
- Overly conscientious
- Pleasure deferring
- Self doubt

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Environment

+

- 80 hours working
- 24 hours awake
- Change
- Little time for family/significant others
- Loneliness and social isolation
- Work overload
- Overwhelming responsibility
- Exposure to pain, suffering, death, dying
- Continual high stakes assessment
- “I can never read enough!”

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House Officer Syndrome

- Episodic Cognitive Impairment
- Chronic Anger and Resentment
- Family/Significant Other Discord
- Pervasive Cynicism

Gary W. Small, MD
"House Officer Stress Syndrome"
Psychosomatics 22:860-865, 1981

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Why now?

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A Deepening Awareness

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Greg Feldman, MD

March 19, 1977 – November 15, 2010

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2014

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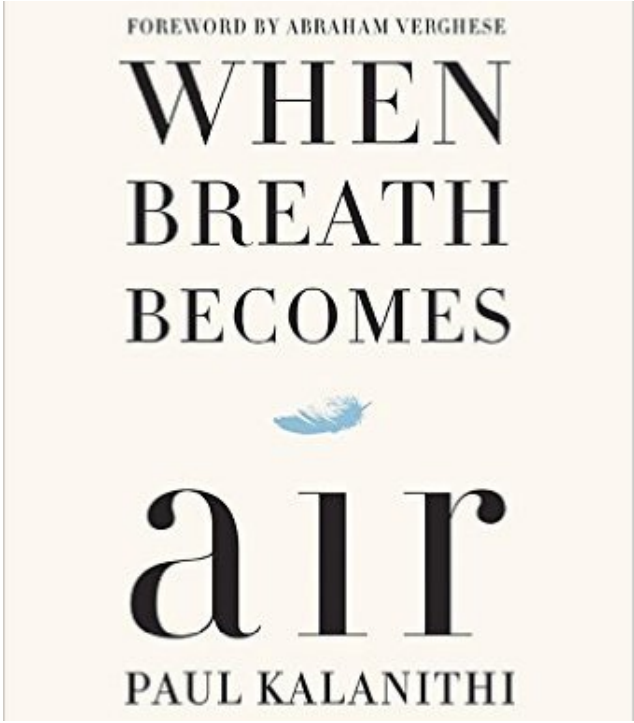
FOREWORD BY ABRAHAM VERGHESE
WHEN
BREATH
BECOMES
air
PAUL KALANITHI

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OPEN

Research Report

Causes of Death of Residents in ACGME-Accredited Programs 2000 Through 2014: Implications for the Learning Environment

Nicholas A. Yaghmour, MPP, Timothy P. Brigham, MDiv, PhD, Thomas Richter, MA, Rebecca S. Miller, MS, Ingrid Philibert, PhD, MBA, DeWitt C. Baldwin Jr, MD, and Thomas J. Nasca, MD

Abstract

Purpose
To systematically study the number of U.S. resident deaths from all causes, including suicide.

Method
The more than 9,900 programs accredited by the Accreditation Council for Graduate Medical Education (ACGME) annually report the status of residents. The authors aggregated ACGME data on 381,614 residents in training during years 2000 through 2014. Names of residents reported as deceased were submitted to the National Death Index to learn causes of death. Person-year calculations were used to establish resident death rates and compare them with those in the general population.

Results
Between 2000 and 2014, 324 individuals (220 men, 104 women) died while in residency. The leading cause of death was neoplastic disease, followed by suicide, accidents, and other diseases. For male residents the leading cause was suicide, and for female residents, malignancies. Resident death rates were lower than in the age- and gender-matched general population. Temporal patterns showed higher rates of death early in residency. Deaths by suicide were higher early in training, and during the first and third quarters of the academic year. There was no upward or downward trend in resident deaths over the 15 years of this study.

Conclusions
Neoplastic disease and suicide were the leading causes of death in residents. Data for death by suicide suggest added risk early in residency and during certain months of the academic year. Providing trainees with a supportive environment and with medical and mental health services is integral to reducing preventable deaths and fostering a healthy physician workforce.

In 2014, the suicide-related deaths of two internal medicine interns in New York[1] shocked the public and the profession, and refocused attention on physician suicide, a concern for several decades. A study by Center et al[2] found that an estimated 300 to 400 practicing physicians died by suicide each year, burnout, and suicidal ideation than are their peers in the general population.[4–6] However, the causes of death for physicians in training have not been systematically studied.

The Accreditation Council for Graduate Medical Education (ACGME)

Method

The ACGME maintains information about U.S. accredited graduate medical education programs, including the number of residents enrolled in a given program for each academic year.[7] Programs annually update their information using the Accreditation Data

IRB Approved Protocol
National Death Index
381,614 Residents over
15 years
1,622,939 person years
918,654 male
704,285 female
324 residents died
during training

Yaghmour, N.A., Brigham, T.P., Richter, T., Miller, R., Philibert, I., Baldwin Jr., D.C., Nasca, T.J.
Causes of death among residents enrolled in ACGME accredited programs from 2000 through 2014. Academic Medicine,2017.92:976-983.

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Frequencies of Death by Category

Category	Frequency	Percent
Neoplastic Diseases	80	24.69%
Suicide	66	20.37%
Other Medical and Surgical Diseases	51	15.74%
Accidents	51	15.74%
Ill Defined or Undetermined	28	8.64%
Accidental Poisoning	22	6.79%
Undetermined Intent, Poisoning and Falls	11	3.40%
Infectious Disease	8	2.47%
Homicide	7	2.16%

Yaghmour, NA, Brigham, TP, Richter, T, Miller, R, Philibert, I, Baldwin Jr. DC, Nasca, TJ. **Causes of death among residents enrolled in ACGME accredited programs from 2000 through 2014. Academic Medicine, Accepted for Publication 3/2017. *In Press.***

T. Nasca
2017

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Cause of Death by Year in Program

	1	2	3	4	5	Total
Neoplastic Diseases	31	23	20	6	0	80
Suicide	31	19	8	6	2	66
Other Medical and Surgical Diseases	21	14	14	2	0	51
Accidents	22	12	10	5	2	51
Ill Defined or Undetermined	14	9	3	2	0	28
Accidental Poisoning	6	9	6	1	0	22
Undetermined Intent, Poisoning and Falls	4	2	3	1	1	11
Infectious Disease	3	2	2	1	0	8
Homicide	2	2	2	0	1	7
Total	134	92	68	24	6	324

Academic Medicine,2017.92:976-983.

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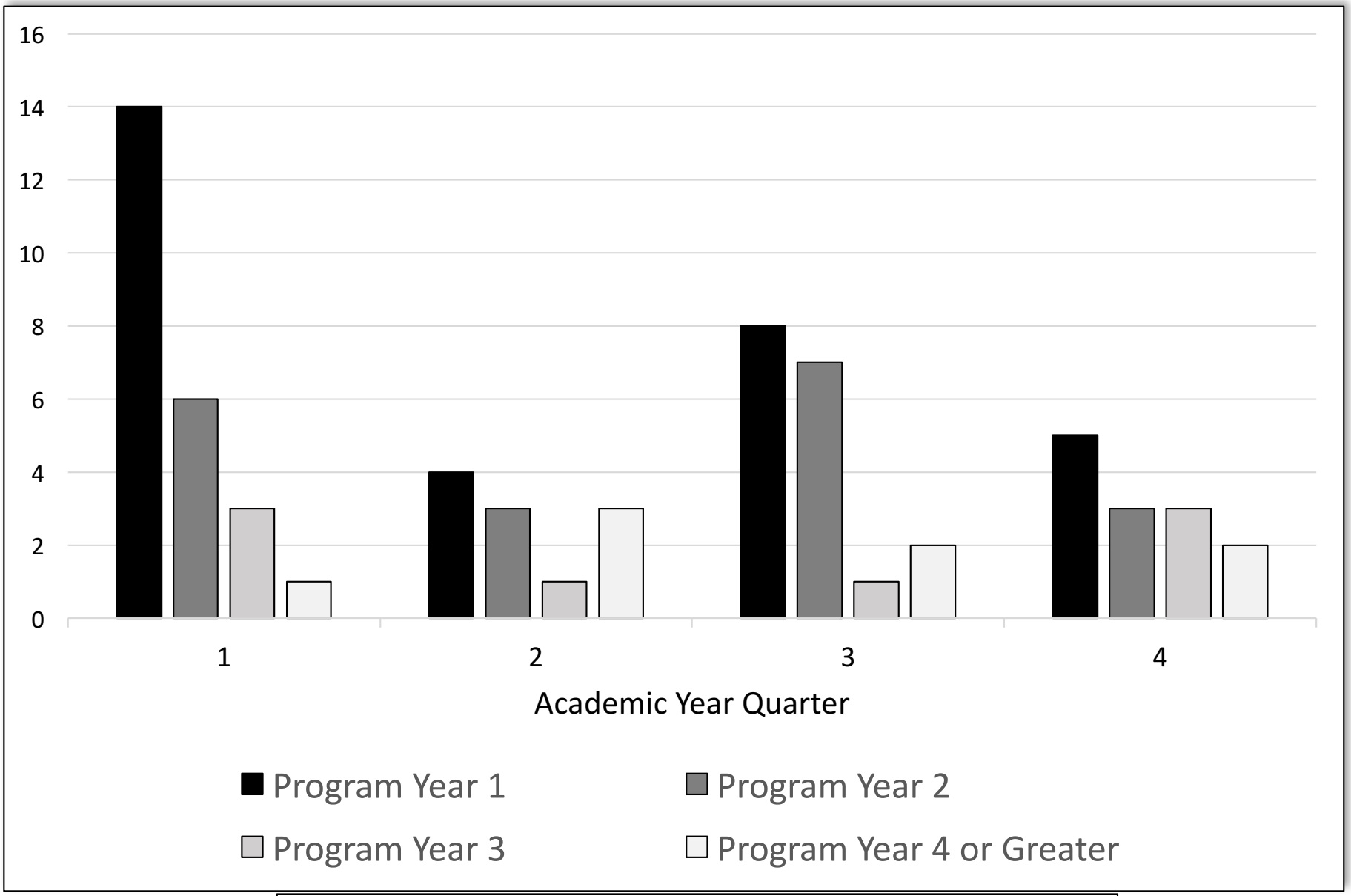
Resident Suicides (#) By Academic Year, Quarter, and Residency Program Year



Yaghmour, NA, Brigham, TP, Richter, T, Miller, R, Philibert, I, Baldwin Jr. DC, Nasca, TJ. **Causes of death among residents enrolled in ACGME accredited programs from 2000 through 2014. Academic Medicine, Accepted for Publication 3/2017. *In Press.***

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2017

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Devastation

- One is too many
- Crisis of Confidence and Self Doubt
  - Healers
- Family

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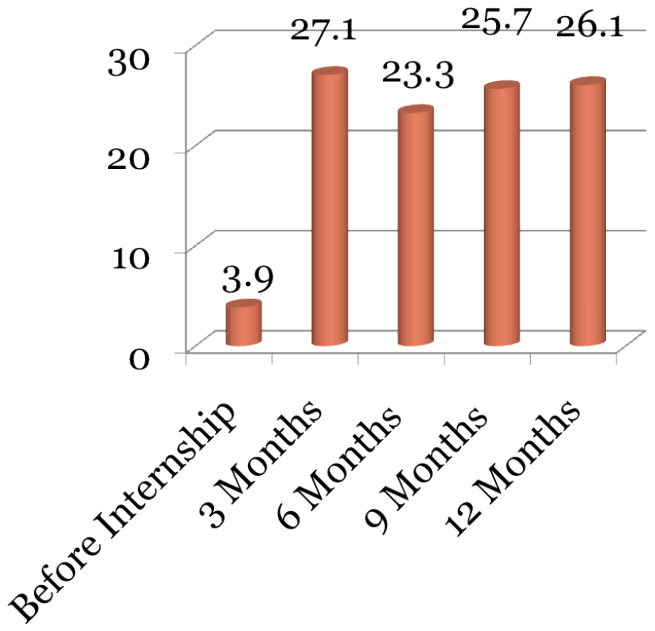
Depression During Internship

Specialty (N=740)

- Internal medicine 358 (48.5)
- General surgery 98 (13.3)
- OB/gynecology 42 (5.7)
- Pediatrics 94 (12.7)
- Psychiatry 63 (8.5)
- Emergency medicine 47 (6.3)
- Medicine/pediatrics 19 (2.6)
- Family medicine 19 (2.6)

Percentage with "Depression" (PHQ >10)



Mean PHQ-9 increased from 2.4 to 6.4

Sen et al, Arch Gen Psych 2010

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Practicing Physician (Faculty) Concerns

- Well-being
- Burnout
- Suicide

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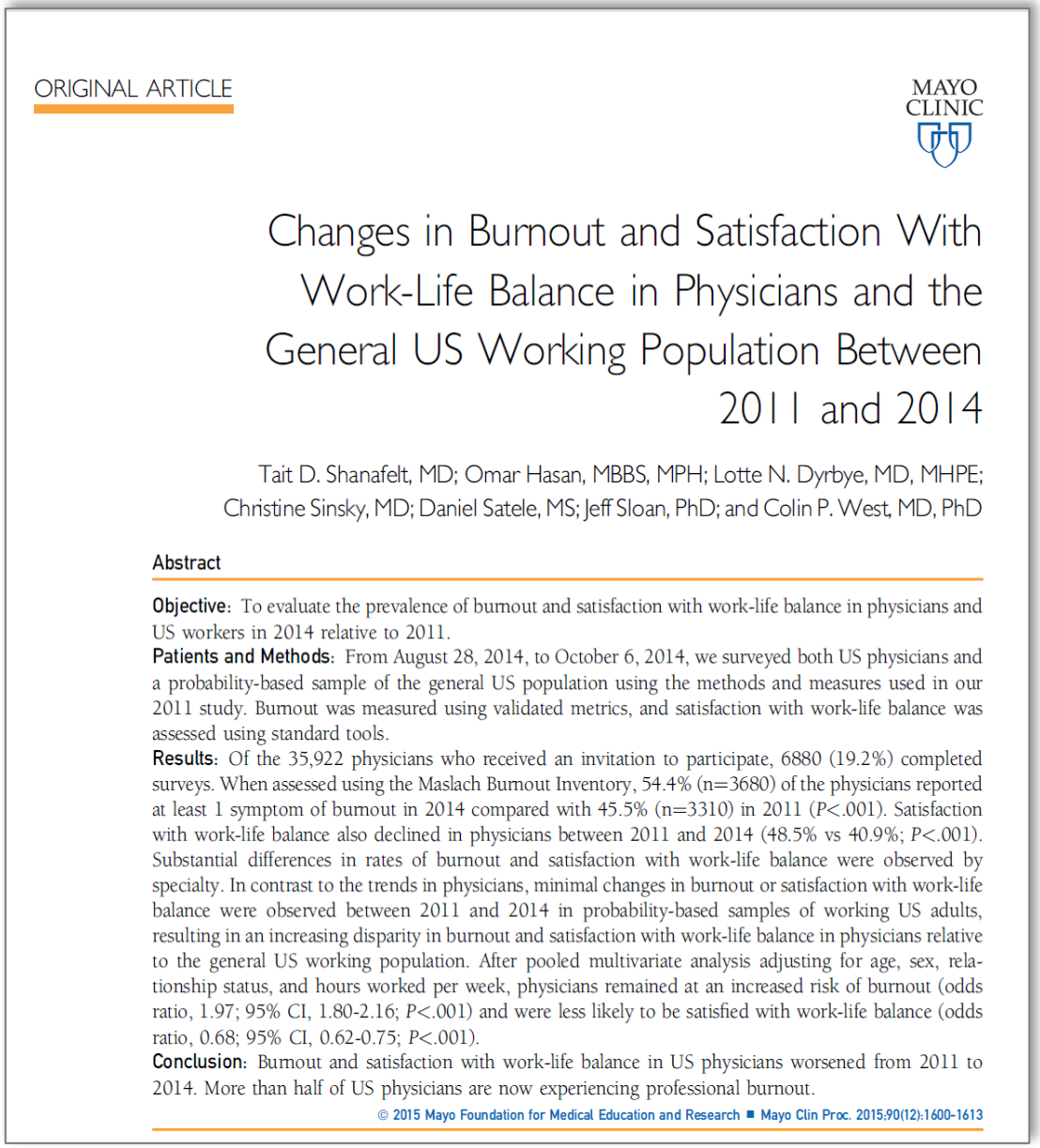
Burnout Increasing Across All Specialties



ORIGINAL ARTICLE

MAYO CLINIC

Changes in Burnout and Satisfaction With Work-Life Balance in Physicians and the General US Working Population Between 2011 and 2014

Tait D. Shanafelt, MD; Omar Hasan, MBBS, MPH; Lotte N. Dyrbye, MD, MHPE; Christine Sinsky, MD; Daniel Satele, MS; Jeff Sloan, PhD; and Colin P. West, MD, PhD

Abstract

Objective: To evaluate the prevalence of burnout and satisfaction with work-life balance in physicians and US workers in 2014 relative to 2011.

Patients and Methods: From August 28, 2014, to October 6, 2014, we surveyed both US physicians and a probability-based sample of the general US population using the methods and measures used in our 2011 study. Burnout was measured using validated metrics, and satisfaction with work-life balance was assessed using standard tools.

Results: Of the 35,922 physicians who received an invitation to participate, 6880 (19.2%) completed surveys. When assessed using the Maslach Burnout Inventory, 54.4% (n=3680) of the physicians reported at least 1 symptom of burnout in 2014 compared with 45.5% (n=3310) in 2011 ($P<.001$). Satisfaction with work-life balance also declined in physicians between 2011 and 2014 (48.5% vs 40.9%; $P<.001$). Substantial differences in rates of burnout and satisfaction with work-life balance were observed by specialty. In contrast to the trends in physicians, minimal changes in burnout or satisfaction with work-life balance were observed between 2011 and 2014 in probability-based samples of working US adults, resulting in an increasing disparity in burnout and satisfaction with work-life balance in physicians relative to the general US working population. After pooled multivariate analysis adjusting for age, sex, relationship status, and hours worked per week, physicians remained at an increased risk of burnout (odds ratio, 1.97; 95% CI, 1.80-2.16; $P<.001$) and were less likely to be satisfied with work-life balance (odds ratio, 0.68; 95% CI, 0.62-0.75; $P<.001$).

Conclusion: Burnout and satisfaction with work-life balance in US physicians worsened from 2011 to 2014. More than half of US physicians are now experiencing professional burnout.

© 2015 Mayo Foundation for Medical Education and Research ■ Mayo Clin Proc. 2015;90(12):1600-1613

Shanafelt, TD; Hasan, O; Dyrbye, LN; Sinsky, C; Satele, D; Sloan, J; West, CP. Mayo Clin Proc. 2015;90(12):1600-1613

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2017

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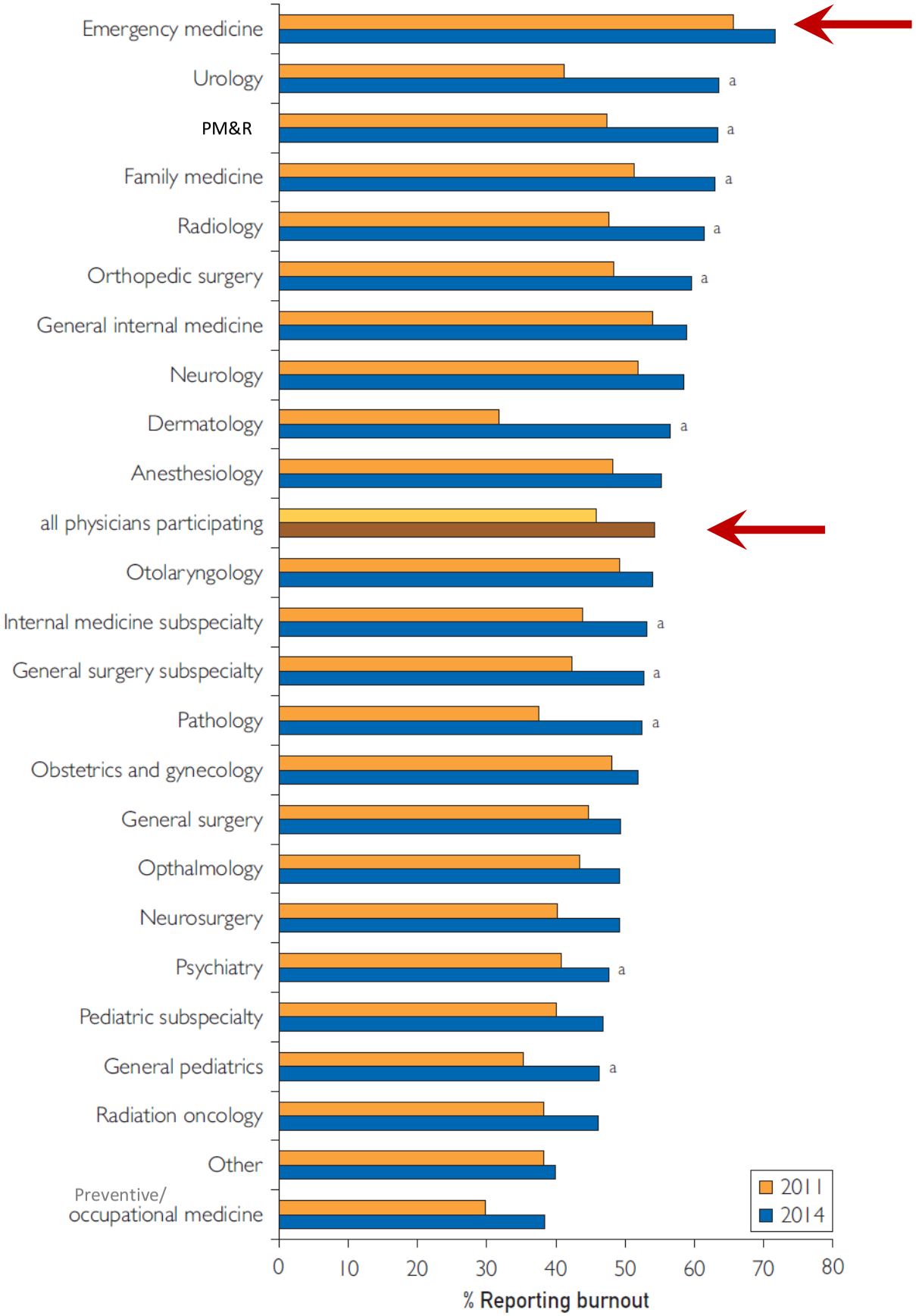
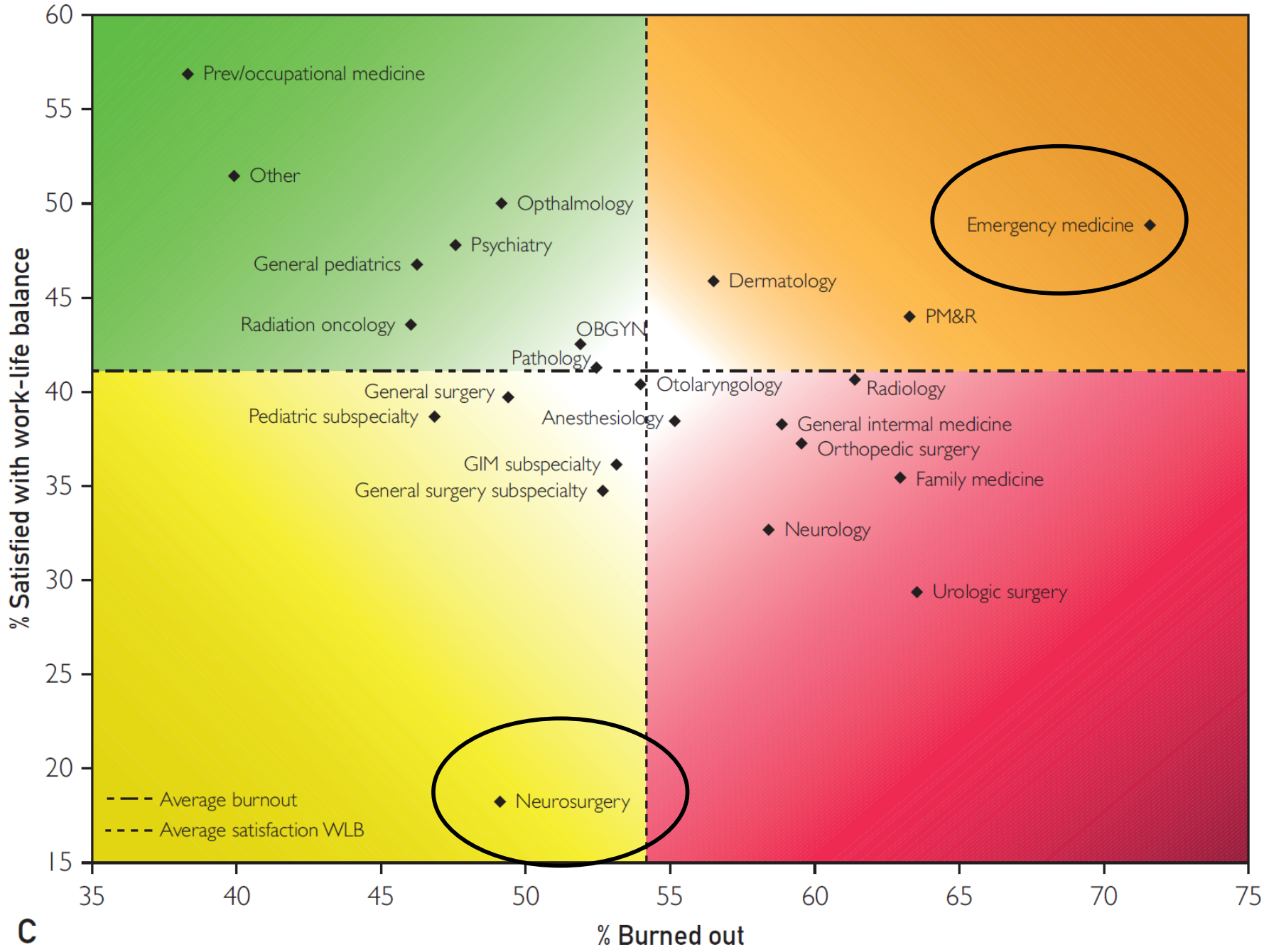


Shanafelt, TD, et.al. Mayo Clin Proc. 2015;90(12):1600-1613 with TJN Modifications



Shanafelt, TD, et.al. Mayo Clin Proc. 2015;90(12):1600-1613 with TJN Modifications

T. Nasca 2017

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Moral Distress

- More than burnout

- The sense that we know and need to do the right thing but unable to do it

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Suicide Among Practicing Physicians

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Increasing National Attention

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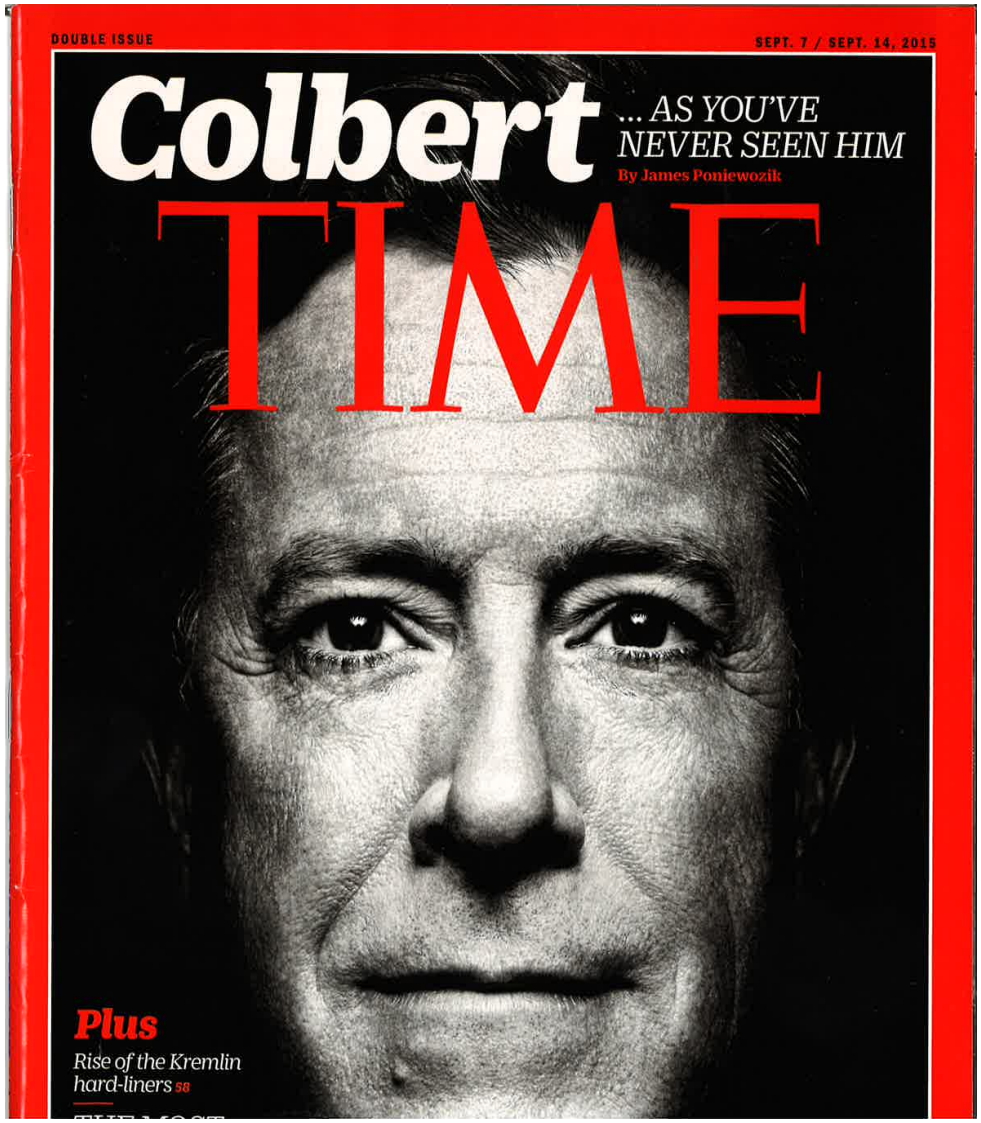
DOUBLE ISSUE
SEPT. 7 / SEPT. 14, 2015
Colbert
... AS YOU'VE NEVER SEEN HIM
By James Poniewozik
TIME
Plus
Rise of the Kremlin hard-liners 58

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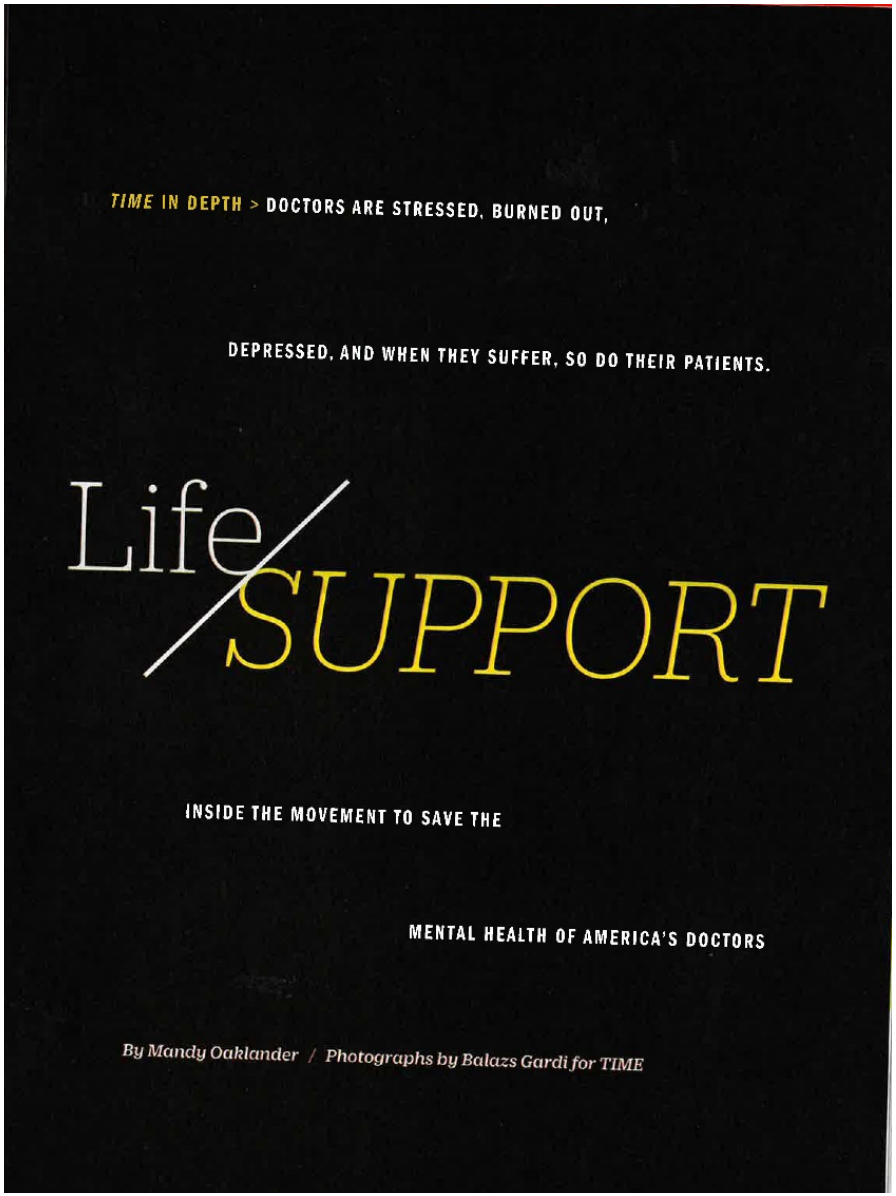
TIME IN DEPTH > DOCTORS ARE STRESSED, BURNED OUT,
DEPRESSED, AND WHEN THEY SUFFER, SO DO THEIR PATIENTS.
Life SUPPORT
INSIDE THE MOVEMENT TO SAVE THE
MENTAL HEALTH OF AMERICA'S DOCTORS
By Mandy Oaklander / Photographs by Balazs Gardi for TIME

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What to do?

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"Every system is perfectly designed to yield the result it produces."

Paul Batalden

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Fundamental Transformative Change

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Why us?

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“Somebody has to do something,
and it’s just incredibly pathetic
that it has to be us.”

Jerry Garcia

The Grateful Dead

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Next Steps

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We are aware that the ACGME cannot solve this challenge alone.

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$$B = f(P, E)$$

Lewin's Equation 1936

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ACGME's Strategy and Role in **Resident Physician Well-Being**
Address the need in the Graduate Medical Education Community

Convene and support the GME Community

- Internal Task Force to understand the scope of resident and physician suicide
- "Call to Arms" at the March, 2015 Annual Educational Conference
- Formation of an ACGME Board Task Force on Physician Well-Being
- Annual ACGME Symposia on Physician Well-Being starting in 2015
- Remolding of CLER Visit Program to include Clinician Well-Being 2016
- Revision of the Common Program Requirements, 2015-Present
  - Common Framework to Address Context
- Disseminate tools, salutary practices, new knowledge
  - To Bring About Culture Change

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Well-Being

- Symposium
- Tools and Resources
- Resident Survey
- Back to Bedside
- National Academy of Medicine (NAM)

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ACCREDITATION COUNCIL FOR GRADUATE MEDICAL EDUCATION

SYMPOSIUM ON PHYSICIAN WELL-BEING

FIRST ANNUAL SYMPOSIUM: NOVEMBER 17-18, 2015

SECOND ANNUAL SYMPOSIUM: NOVEMBER 30 -DECEMBER 1, 2016

THIRD ANNUAL SYMPOSIUM: NOVEMBER 29-30, 2017

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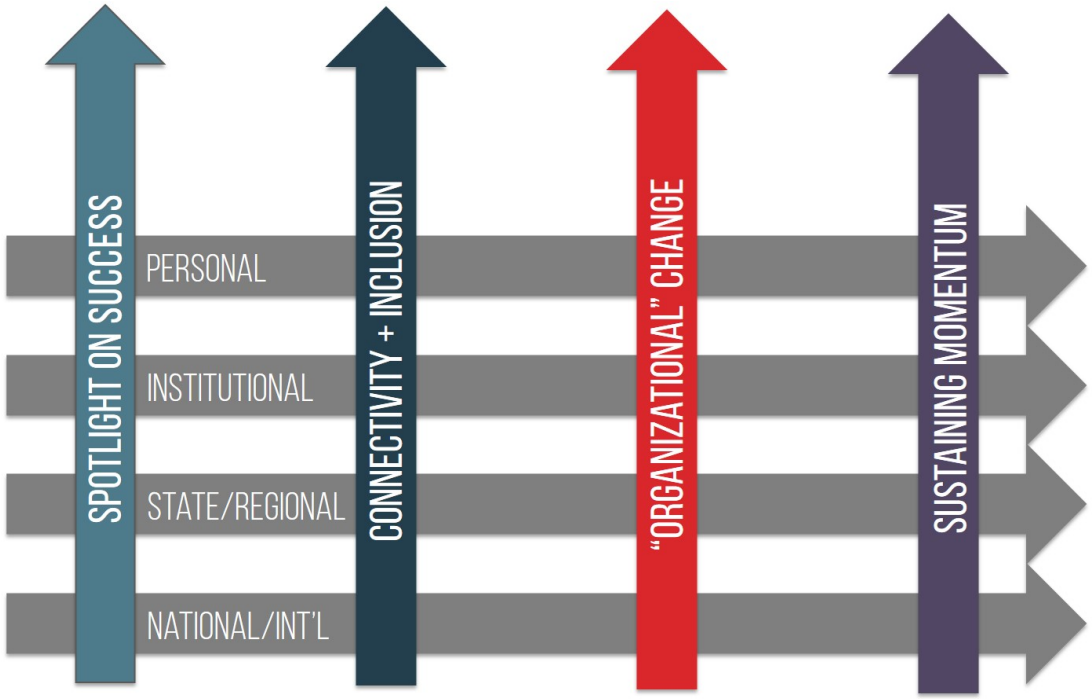
2017 Symposium Focus Areas

- Success
- Connectedness & Inclusion
- Organizational Change
- Momentum



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Tools and Resources

For Resident and Faculty Member Well-Being

Common Program Requirements
Section VI

VI.C. **Well-Being**

In the current healthcare environment … Programs, in partnership with their Sponsoring Institutions, have the same responsibility to address well-being as they do to evaluate other aspects of resident competence.

VI.C.1. This responsibility must include:

VI.C.1.e) attention to resident and faculty member burnout, depression, and substance abuse. The program, in partnership with its Sponsoring Institution, must educate faculty members and residents in identification of the symptoms of burnout, depression, and substance abuse, including means to assist those who experience these conditions. Residents and faculty members must also be educated to recognize those symptoms in themselves and how to seek appropriate care. The program, in partnership with its Sponsoring Institution, must: (Core)

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Common Program Requirements
Section VI

VI.C.1.e)

Background and Intent: Programs and Sponsoring Institutions are encouraged to review materials in order to create systems for identification of burnout, depression, and substance abuse. Materials and more information are available on the Physician Well-Being section of the ACGME website (http://www.acgme.org/What-We-Do/Initiatives/Physician-Well-Being).

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Tools and Resources
Selection Criteria

1. **Five Content Areas**
   - Directly related to Section VI requirements
   - Items from Sections I-V may be addressed in the future
2. **Must be useful to a broad, external audience**
3. **May be either Open-Access or Proprietary**
4. **Must have been created for—or used with—physicians**
5. **Preference given to tools and resources with existing validity evidence**

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Tools and Resources
Five Content Areas

1. Identifying and Addressing Burnout
2. Promoting Well-Being
3. Assessing and Addressing Emotional and Psychological Distress / Depression / Suicide
4. Improving the Learning and Working Environment
5. Coping with Tragedy

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Tools and Resources
Website Update

- **Designed to make tools and resources accessible and easy to find**
- **Identifies each tool or resource by type of use** (screening / survey instrument, educational module, etc.)
- **Designates proprietary items, as such**

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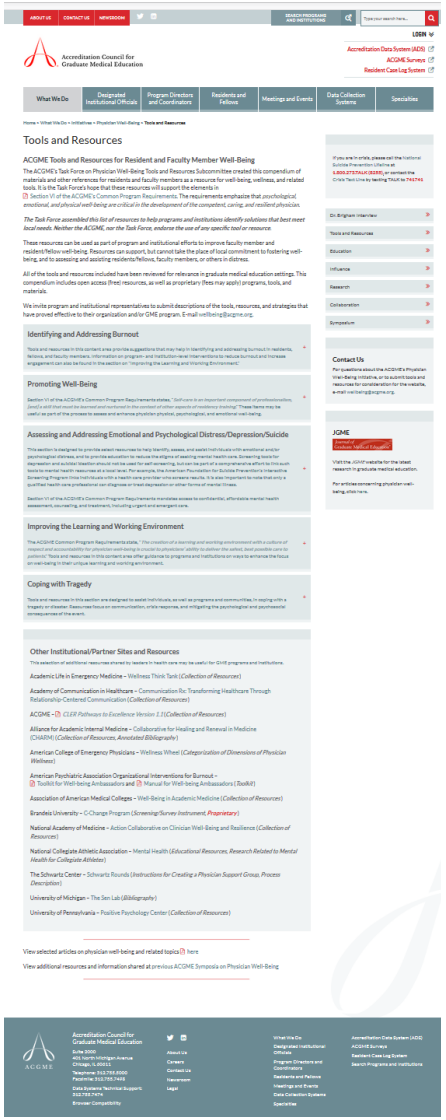

Tools and Resources

ACGME Tools and Resources for Resident and Faculty Member Well-Being

Identifying and Addressing Burnout

Promoting Well-Being

Assessing and Addressing Emotional and Psychological Distress/Depression/Suicide

Improving the Learning and Working Environment

Coping with Tragedy

Other Institutional/Partner Sites and Resources

If you are in crisis, please call the National Suicide Prevention Lifeline at 1.800.273.TALK (8255), or contact the Crisis Text Line by texting TALK to 741741

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Identifying and Addressing Burnout

Tools and resources in this content area provide suggestions that may help in identifying and addressing burnout in residents, fellows, and faculty members. Information on program- and institution-level interventions to reduce burnout and increase engagement can also be found in the section on "Improving the Learning and Working Environment."

Promoting Well-Being

Section VI of the ACGME's Common Program Requirements states, "*Self-care is an important component of professionalism, [and] a skill that must be learned and nurtured in the context of other aspects of residency training.*" These items may be useful as part of the process to assess and enhance physician physical, psychological, and emotional well-being.

Assessing and Addressing Emotional and Psychological Distress/Depression/Suicide

This section is designed to provide select resources to help identify, assess, and assist individuals with emotional and/or psychological distress, and to provide education to reduce the stigma of seeking mental health care. Screening tools for depression and suicidal ideation should not be used for self-screening, but can be part of a comprehensive effort to link such tools to mental health resources at a local level. For example, the American Foundation for Suicide Prevention's Interactive Screening Program links individuals with a health care provider who screens results. It is also important to note that only a qualified health care professional can diagnose or treat depression or other forms of mental illness.

Section VI of the ACGME's Common Program Requirements mandates access to confidential, affordable mental health assessment, counseling, and treatment, including urgent and emergent care.

Improving the Learning and Working Environment

The ACGME Common Program Requirements state, "*The creation of a learning and working environment with a culture of respect and accountability for physician well-being is crucial to physicians' ability to deliver the safest, best possible care to patients.*" Tools and resources in this content area offer guidance to programs and institutions on ways to enhance the focus on well-being in their unique learning and working environment.

Coping with Tragedy

Tools and resources in this section are designed to assist individuals, as well as programs and communities, in coping with a tragedy or disaster. Resources focus on communication, crisis response, and mitigating the psychological and psychosocial consequences of the event.

information about concerns or complaints relating to a program.

JGME

Journal of Graduate Medical Education

Visit the *JGME* website for the latest research in graduate medical education.

For articles concerning physician well-being, click here.

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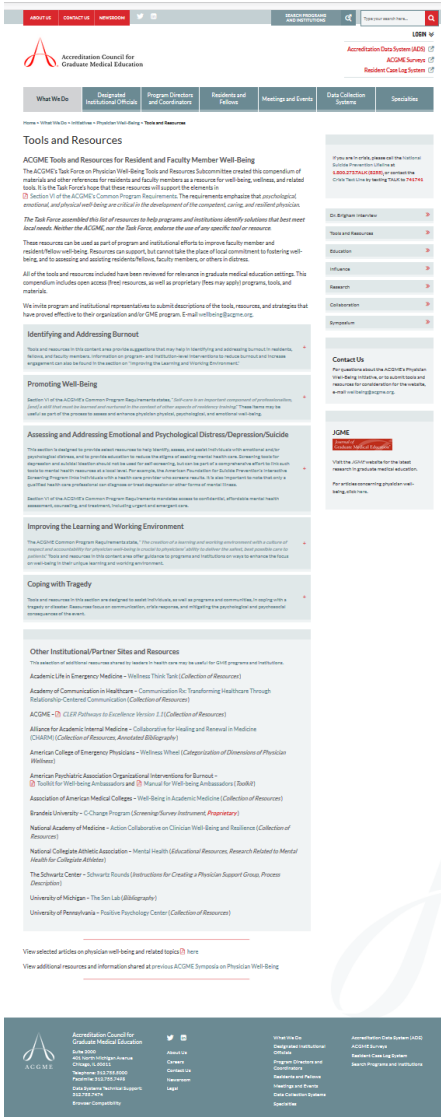

Identifying and Addressing Burnout

Tools and resources in this content area provide suggestions that may help in identifying and addressing burnout in residents, fellows, and faculty members. Information on program- and institution-level interventions to reduce burnout and increase engagement can also be found in the section on "Improving the Learning and Working Environment."

American Medical Association – Mini-Z Burnout Inventory (*Screening/Survey Instrument*)

American Medical Association – Physician Wellness: Preventing Resident and Fellow Burnout (*Educational Module*)

American Medical Association – Preventing Physician Burnout (*Educational Module*)

Maslach Burnout Inventory (*Screening/Survey Instrument, **Proprietary***)

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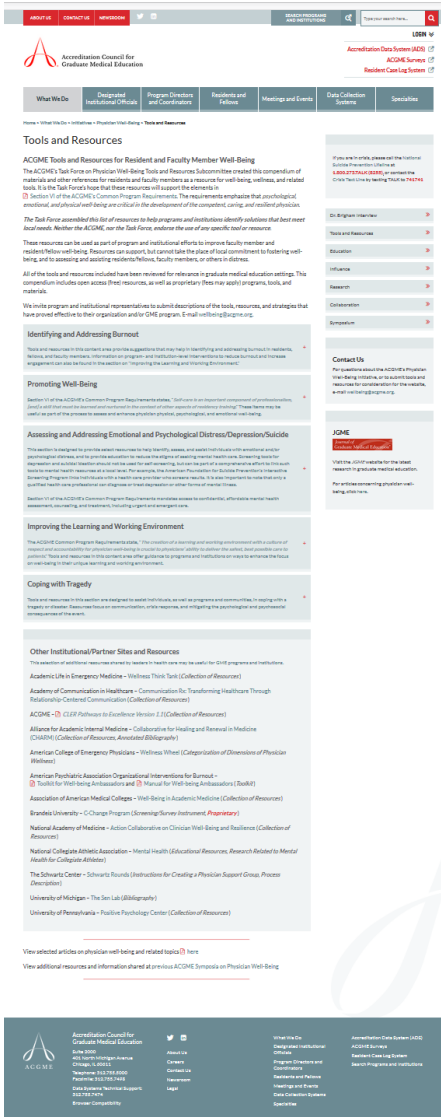

Promoting Well-Being

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American Medical Association – Improving Physician Resiliency (*Educational Module*)

Association of Pediatric Program Directors – Optimizing Your Mentoring Relationship: A Toolkit for Mentors and Mentees Via MedEdPORTAL (*Toolkit*)

LIFE Curriculum Guides: Guide 1 and Guide 2 (*Educational Modules on Resident Well-Being, Fatigue Mitigation, Substance Abuse and Other Challenging Situations*)

Mayo Clinic Well-Being Index (*Screening/Survey Instrument, **Proprietary***)

Professional Quality of Life Scale (*Screening/Survey Instrument*)

Examples of materials designed by specific institutions:

Johns Hopkins Medicine Resident Wellness Toolkit (*Toolkit*)

Oregon Health & Science University Wellness Resources (*Toolkit*)

University of Colorado Well-Being Resources (*Toolkit*)

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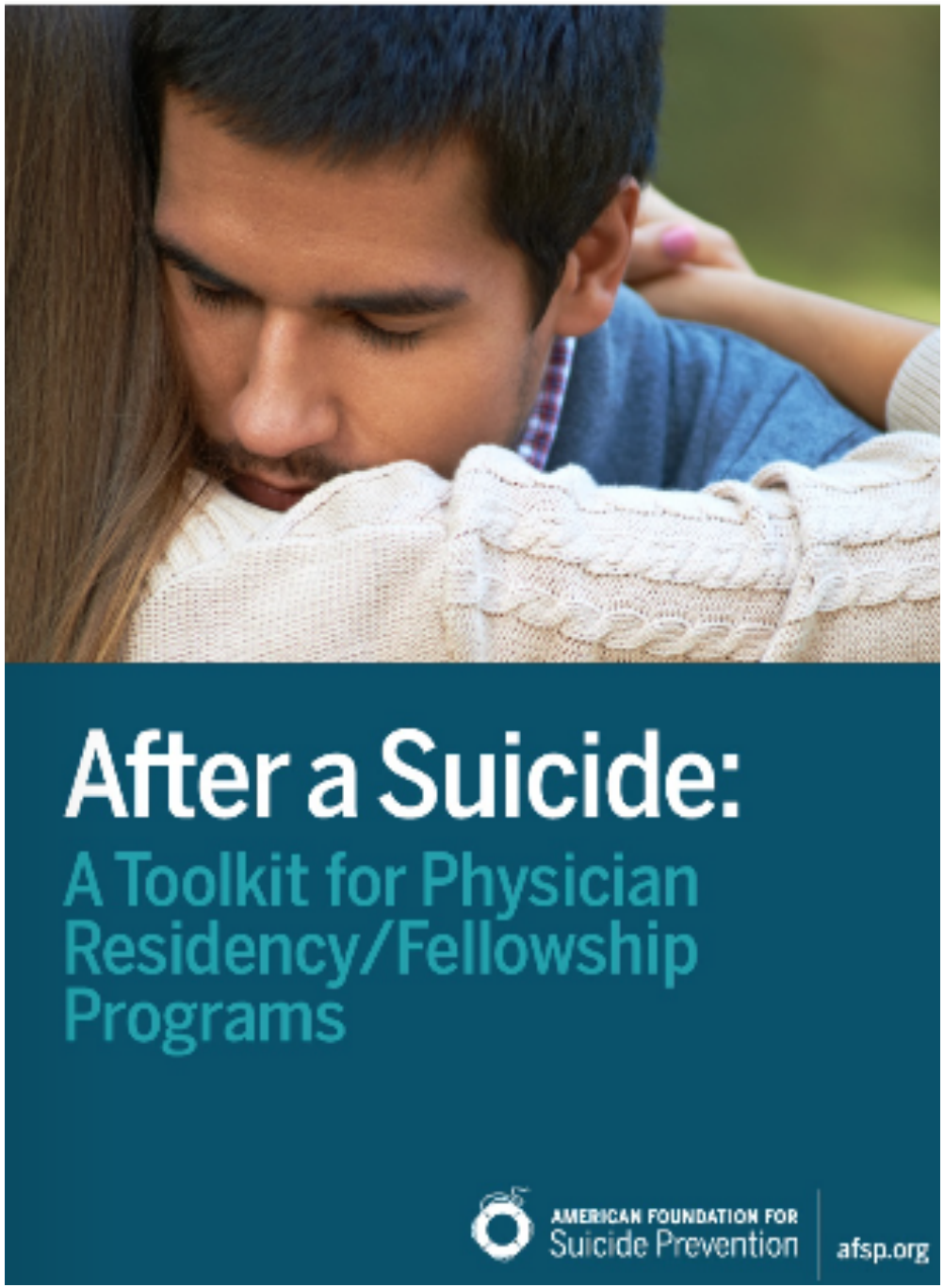
After a Suicide:
A Toolkit for Physician Residency/Fellowship Programs
AMERICAN FOUNDATION FOR
Suicide Prevention
afsp.org

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Other Institutional/Partner Sites and Resources

This selection of additional resources shared by leaders in health care may be useful for GME programs and institutions.

Academic Life in Emergency Medicine – Wellness Think Tank (*Collection of Resources*)

Academy of Communication in Healthcare – Communication Rx: Transforming Healthcare Through Relationship-Centered Communication (*Collection of Resources*)

Alliance for Academic Internal Medicine – Collaborative for Healing and Renewal in Medicine (CHARM) (*Collection of Resources, Annotated Bibliography*)

American College of Emergency Physicians – Wellness Wheel (*Categorization of Dimensions of Physician Wellness*)

Association of American Medical Colleges – Well-Being in Academic Medicine (*Collection of Resources*)

Brandeis University – C-Change Program (*Screening/Survey Instrument, **Proprietary***)

National Academy of Medicine – Action Collaborative on Clinician Well-Being and Resilience (*Collection of Resources*)

National Collegiate Athletic Association – Mental Health (*Educational Resources, Research Related to Mental Health for Collegiate Athletes*)

The Schwartz Center – Schwartz Rounds (*Instructions for Creating a Physician Support Group, Process Description*)

University of Michigan – The Sen Lab (*Bibliography*)

University of Pennsylvania – Positive Psychology Center (*Collection of Resources*)

View additional resources and information shared at previous ACGME Symposia on Physician Well-Being

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Resident Survey

Establishing Baseline Data on Well-Being of Trainees

Back to Bedside

Fostering Meaning in the Learning Environment

BACK TO BEDSIDE

The ACGME Council of Review Committee Residents (CRCR) designed the "*Back to Bedside*" initiative to empower residents and fellows to develop transformative projects that combat burnout by fostering meaning in their learning environments; engaging on a deeper level with what is at the heart of medicine: their patients.

The ACGME received 223 proposals focusing on:

- Creating opportunities for more time engaged in direct, meaningful patient care
- Developing a shared sense of teamwork and respect among colleagues
- Decreasing effort spent on non-clinical, administrative responsibilities
- Fostering a supportive, collegial environment
- Increasing patient satisfaction through more meaningful time with their care delivery team

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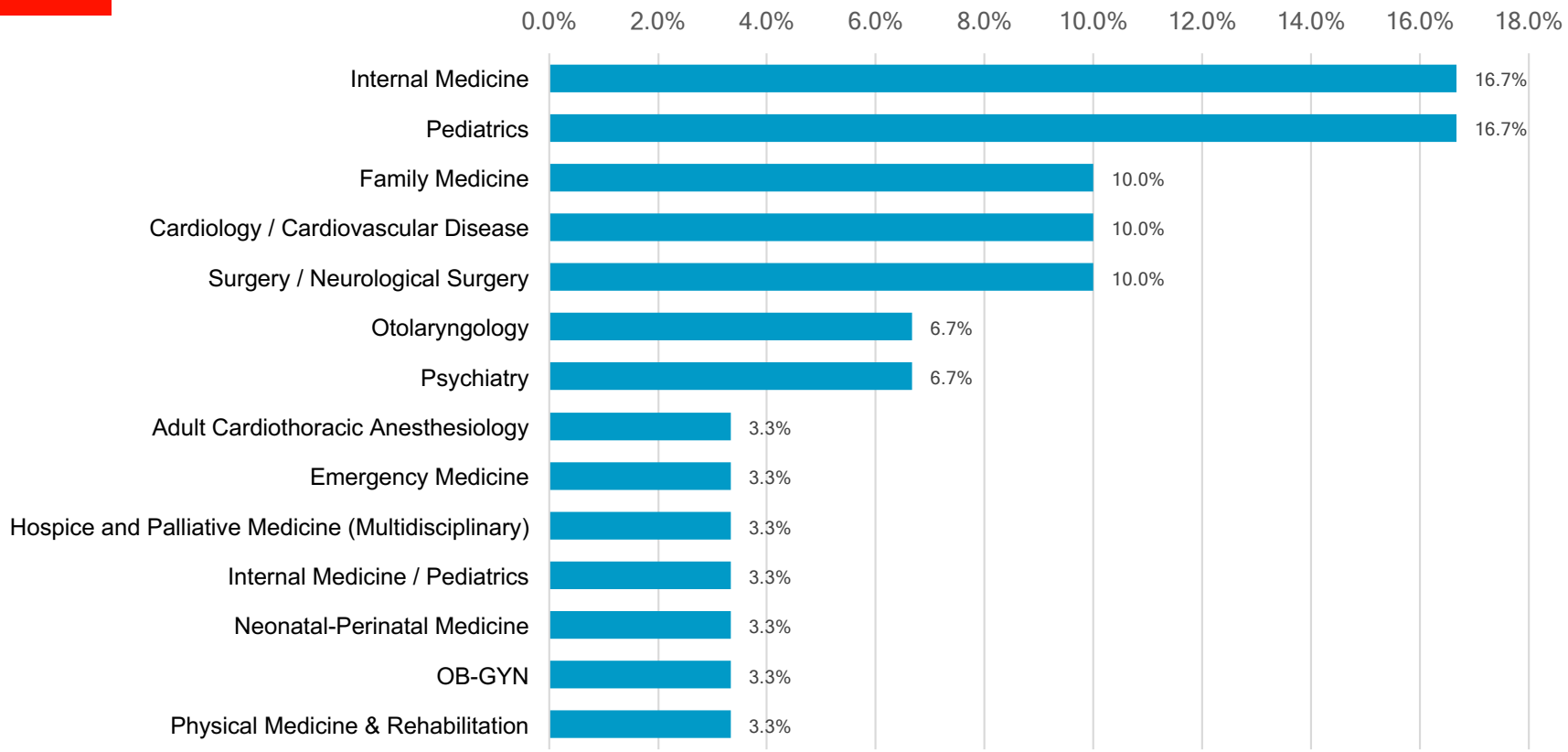
2017 Back to Bedside

Specialty of Project Recipients (n = 30)



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National Academy of Medicine

Action Collaborative on Clinician Well-Being and Resilience

NAM Action Collaborative
Goals

1. **Improve baseline understanding** across organizations of challenges to clinician well-being
2. **Raise visibility** of clinician stress and burnout
3. **Advance evidence-based, multidisciplinary solutions** to reverse depress, anxiety, and burnout, leading to improvements in patient care by caring for the caregiver

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NAM Action Collaborative

Leadership and Support Teams

Chair	Victor Dzau
Co-Chairs	Darrel Kirch Tom Nasca
Chief of Staff Support	Morgan Kanarek Alexander Ommaya Tim Brigham
NAM Staff Support	Charlee Alexander Mar Zindel Kimber Bogard Sharyl Nass

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Organization and Strategy

Network Organizations: 104

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Working Groups

1. Research, Data, and Metrics
2. Conceptual Model
3. Messaging and Communications
4. External Factors and Workflow

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Future Direction

- Extend Collaborative for 2 more years (a total of 4 years)

Consensus Study on Clinician Well-Being

- Statement of Task
- Potential Sponsors
  - Generate list of potential sponsors (philanthropies, federal agencies currently participating, and current network organizations)
  - Begin fundraising for the study (Oct 2017; ramp up Jan 2018)

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Meeting Schedule

2017	2018	2019	2020
January 5-6	February 2	March TBD	March TBD
July 13-14	May 2-3	September TBD	September TBD
December 14-15	October 4-5		

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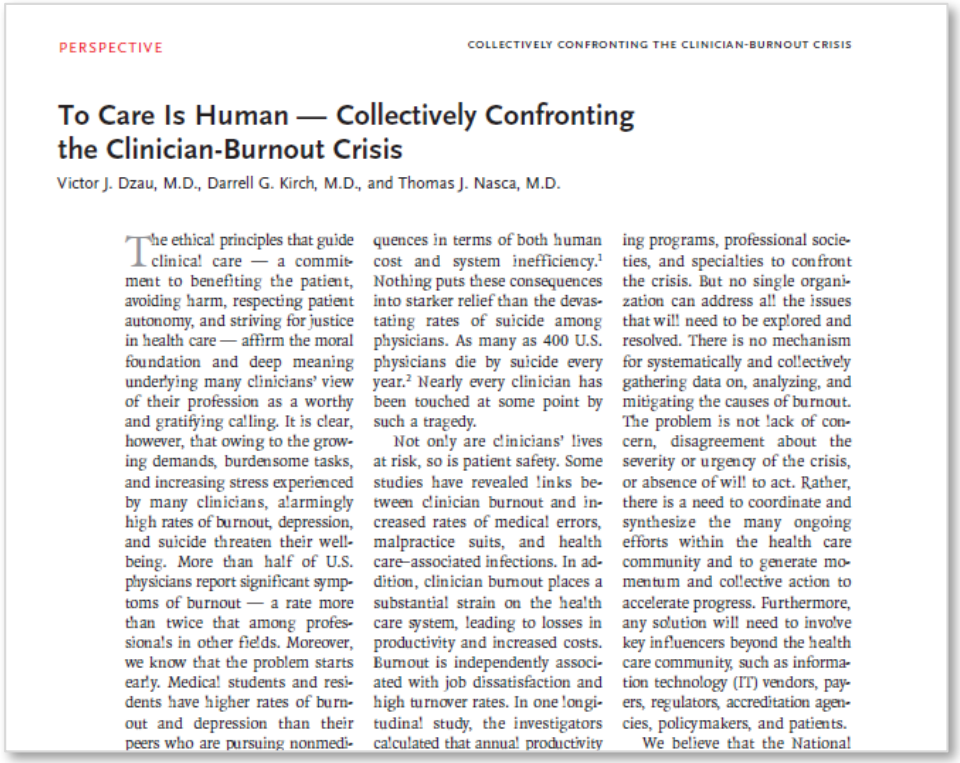
Recent Publications



PERSPECTIVE

COLLECTIVELY CONFRONTING THE CLINICIAN-BURNOUT CRISIS

To Care Is Human — Collectively Confronting the Clinician-Burnout Crisis

Victor J. Dzau, M.D., Darrell G. Kirch, M.D., and Thomas J. Nasca, M.D.

The ethical principles that guide clinical care — a commitment to benefiting the patient, avoiding harm, respecting patient autonomy, and striving for justice in health care — affirm the moral foundation and deep meaning underlying many clinicians' view of their profession as a worthy and gratifying calling. It is clear, however, that owing to the growing demands, burdensome tasks, and increasing stress experienced by many clinicians, alarmingly high rates of burnout, depression, and suicide threaten their well-being. More than half of U.S. physicians report significant symptoms of burnout — a rate more than twice that among professionals in other fields. Moreover, we know that the problem starts early. Medical students and residents have higher rates of burnout and depression than their peers who are pursuing nonmedi-

quences in terms of both human cost and system inefficiency.[1] Nothing puts these consequences into starker relief than the devastating rates of suicide among physicians. As many as 400 U.S. physicians die by suicide every year.[2] Nearly every clinician has been touched at some point by such a tragedy.

Not only are clinicians' lives at risk, so is patient safety. Some studies have revealed links between clinician burnout and increased rates of medical errors, malpractice suits, and health care–associated infections. In addition, clinician burnout places a substantial strain on the health care system, leading to losses in productivity and increased costs. Burnout is independently associated with job dissatisfaction and high turnover rates. In one longitudinal study, the investigators calculated that annual productivity

ing programs, professional societies, and specialties to confront the crisis. But no single organization can address all the issues that will need to be explored and resolved. There is no mechanism for systematically and collectively gathering data on, analyzing, and mitigating the causes of burnout. The problem is not lack of concern, disagreement about the severity or urgency of the crisis, or absence of will to act. Rather, there is a need to coordinate and synthesize the many ongoing efforts within the health care community and to generate momentum and collective action to accelerate progress. Furthermore, any solution will need to involve key influencers beyond the health care community, such as information technology (IT) vendors, payers, regulators, accreditation agencies, policymakers, and patients.

We believe that the National

The NEW ENGLAND JOURNAL of MEDICINE

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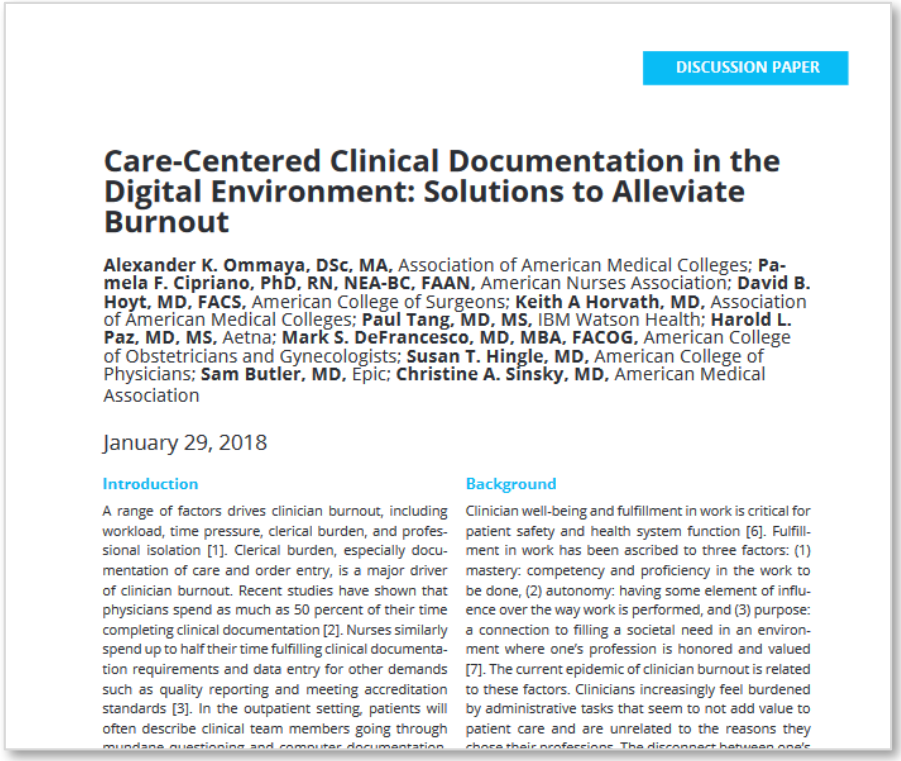
Recent Publications (continued)



DISCUSSION PAPER

Care-Centered Clinical Documentation in the Digital Environment: Solutions to Alleviate Burnout

Alexander K. Ommaya, DSc, MA, Association of American Medical Colleges; **Pamela F. Cipriano, PhD, RN, NEA-BC, FAAN,** American Nurses Association; **David B. Hoyt, MD, FACS,** American College of Surgeons; **Keith A Horvath, MD,** Association of American Medical Colleges; **Paul Tang, MD, MS,** IBM Watson Health; **Harold L. Paz, MD, MS,** Aetna; **Mark S. DeFrancesco, MD, MBA, FACOG,** American College of Obstetricians and Gynecologists; **Susan T. Hingle, MD,** American College of Physicians; **Sam Butler, MD,** Epic; **Christine A. Sinsky, MD,** American Medical Association

January 29, 2018

Introduction

A range of factors drives clinician burnout, including workload, time pressure, clerical burden, and professional isolation [1]. Clerical burden, especially documentation of care and order entry, is a major driver of clinician burnout. Recent studies have shown that physicians spend as much as 50 percent of their time completing clinical documentation [2]. Nurses similarly spend up to half their time fulfilling clinical documentation requirements and data entry for other demands such as quality reporting and meeting accreditation standards [3]. In the outpatient setting, patients will often describe clinical team members going through

Background

Clinician well-being and fulfillment in work is critical for patient safety and health system function [6]. Fulfillment in work has been ascribed to three factors: (1) mastery: competency and proficiency in the work to be done, (2) autonomy: having some element of influence over the way work is performed, and (3) purpose: a connection to filling a societal need in an environment where one's profession is honored and valued [7]. The current epidemic of clinician burnout is related to these factors. Clinicians increasingly feel burdened by administrative tasks that seem to not add value to patient care and are unrelated to the reasons they

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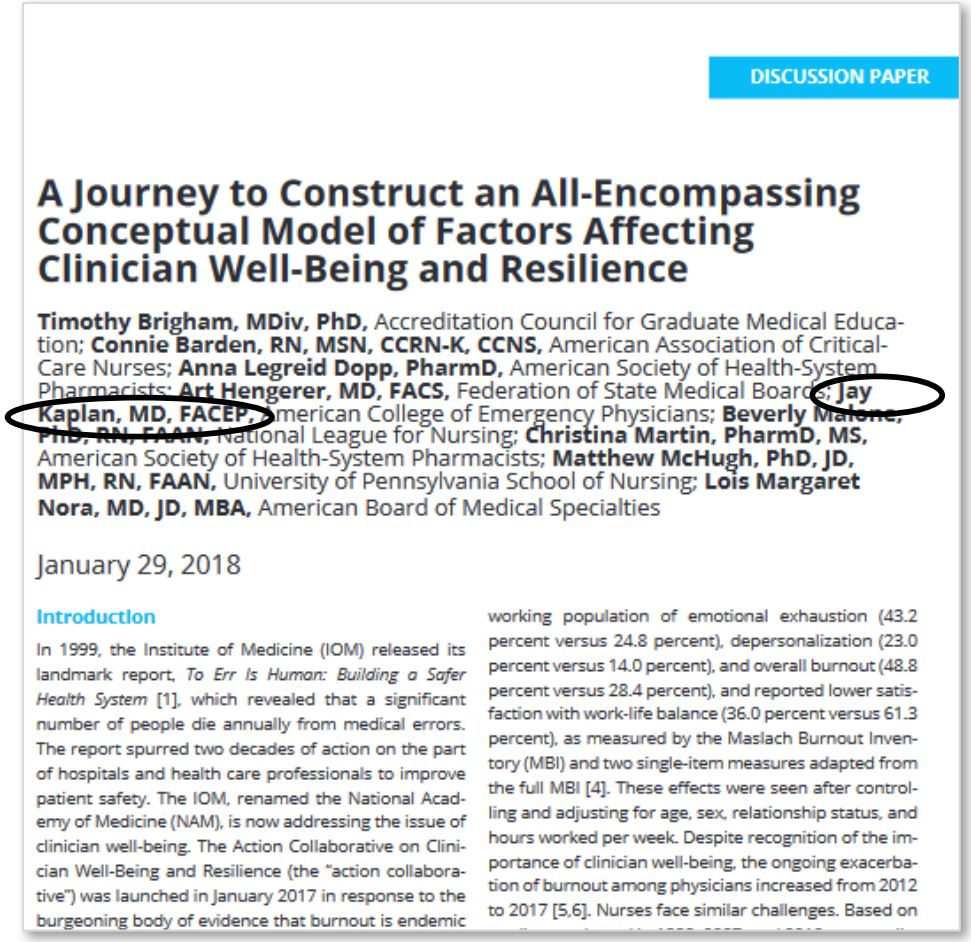
Recent Publications (continued)



DISCUSSION PAPER

A Journey to Construct an All-Encompassing Conceptual Model of Factors Affecting Clinician Well-Being and Resilience

Timothy Brigham, MDiv, PhD, Accreditation Council for Graduate Medical Education; **Connie Barden, RN, MSN, CCRN-K, CCNS,** American Association of Critical-Care Nurses; **Anna Legreid Dopp, PharmD,** American Society of Health-System Pharmacists; **Art Hengerer, MD, FACS,** Federation of State Medical Boards; **Jay Kaplan, MD, FACEP,** American College of Emergency Physicians; **Beverly Malone, PhD, RN, FAAN,** National League for Nursing; **Christina Martin, PharmD, MS,** American Society of Health-System Pharmacists; **Matthew McHugh, PhD, JD, MPH, RN, FAAN,** University of Pennsylvania School of Nursing; **Lois Margaret Nora, MD, JD, MBA,** American Board of Medical Specialties

January 29, 2018

Introduction

In 1999, the Institute of Medicine (IOM) released its landmark report, *To Err Is Human: Building a Safer Health System* [1], which revealed that a significant number of people die annually from medical errors. The report spurred two decades of action on the part of hospitals and health care professionals to improve patient safety. The IOM, renamed the National Academy of Medicine (NAM), is now addressing the issue of clinician well-being. The Action Collaborative on Clinician Well-Being and Resilience (the "action collaborative") was launched in January 2017 in response to the burgeoning body of evidence that burnout is endemic working population of emotional exhaustion (43.2 percent versus 24.8 percent), depersonalization (23.0 percent versus 14.0 percent), and overall burnout (48.8 percent versus 28.4 percent), and reported lower satisfaction with work-life balance (36.0 percent versus 61.3 percent), as measured by the Maslach Burnout Inventory (MBI) and two single-item measures adapted from the full MBI [4]. These effects were seen after controlling and adjusting for age, sex, relationship status, and hours worked per week. Despite recognition of the importance of clinician well-being, the ongoing exacerbation of burnout among physicians increased from 2012 to 2017 [5,6]. Nurses face similar challenges. Based on

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FACTORS AFFECTING CLINICIAN WELL-BEING AND RESILIENCE

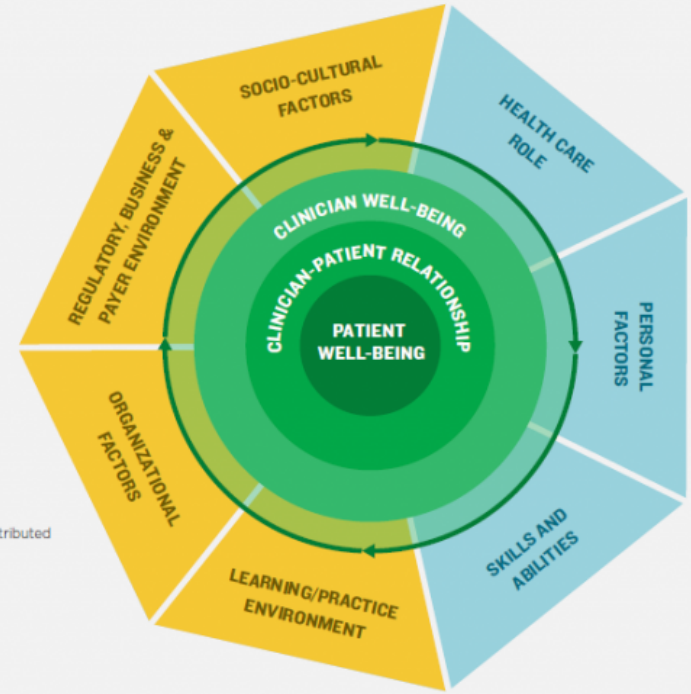
EXTERNAL FACTORS

SOCIO-CULTURAL FACTORS
- Alignment of societal expectations and clinician's role
- Culture of safety and transparency
- Discrimination and overt and unconscious bias
- Media portrayal
- Patient behaviors and expectations
- Political and economic climates
- Social determinants of health
- Stigmatization of mental illness

REGULATORY, BUSINESS, & PAYER ENVIRONMENT
- Accreditation, high-stakes assessments, and publicized quality ratings
- Documentation and reporting requirements
- HR policies and compensation issues
- Initial licensure and certification
- Insurance company policies
- Litigation risk
- Maintenance of licensure and certification
- National and state policies and practices
- Reimbursement structure
- Shifting systems of care and administrative requirements

ORGANIZATIONAL FACTORS
- Bureaucracy
- Congruent organizational mission and values
- Culture, leadership, and staff engagement
- Data collection requirements
- Diversity and Inclusion
- Level of support for all healthcare team members
- Professional development opportunities
- Scope of practice
- Workload, performance, compensation, and value attributed to work elements

LEARNING/PRACTICE ENVIRONMENT
- Autonomy
- Collaborative vs. competitive environment
- Curriculum
- Health IT interoperability and usability/Electronic health records
- Learning and practice setting
- Mentorship
- Physical learning and practice conditions
- Professional relationships
- Student affairs policies
- Student-centered and patient-centered focus
- Team structures and functionality
- Workplace safety and violence



INDIVIDUAL FACTORS

HEALTH CARE ROLE
- Administrative responsibilities
- Alignment of responsibility and authority
- Clinical responsibilities
- Learning/career stage
- Patient population
- Specialty related issues
- Student/trainee responsibilities
- Teaching and research responsibilities

PERSONAL FACTORS
- Inclusion and connectivity
- Family dynamics
- Financial stressors/economic vitality
- Flexibility and ability to respond to change
- Level of engagement/connection to meaning and purpose in work
- Personality traits
- Personal values, ethics and morals
- Physical, mental, and spiritual well-being
- Relationships and social support
- Sense of meaning
- Work-life integration

SKILLS AND ABILITIES
- Clinical Competency level/experience
- Communication skills
- Coping skills
- Delegation
- Empathy
- Management and leadership
- Mastering new technologies or proficient use of technology
- Mentorship
- Optimizing work flow
- Organizational skills
- Resilience
- Teamwork skills

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What can you/we do?

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National Academy of Medicine
Action Collaborative on
Clinician Well-Being and Resilience

Organizational Commitment Statements

- American Academy of Emergency Medicine
- American Academy of Emergency Medicine's Resident and Student Association
- American College of Emergency Physicians
- Council of Emergency Medicine Residency Directors
- Society for Academic Emergency Medicine

Go to https://nam.edu/initiatives/clinician-resilience-and-well-being/commitment-statements-clinician-well-being/ for complete listing

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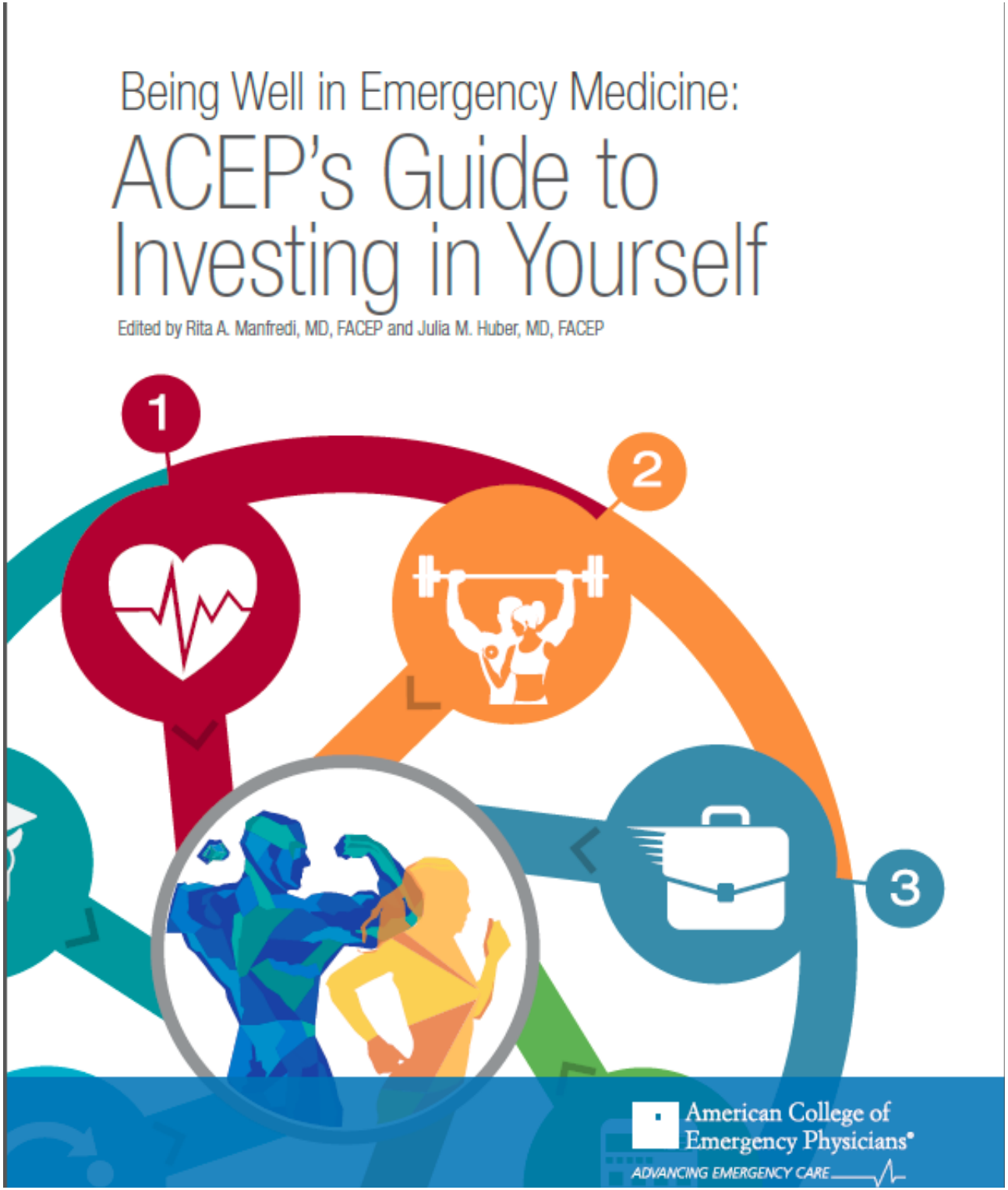
Being Well in Emergency Medicine:
ACEP's Guide to Investing in Yourself
Edited by Rita A. Manfredi, MD, FACEP and Julia M. Huber, MD, FACEP
1
2
3
American College of Emergency Physicians
ADVANCING EMERGENCY CARE

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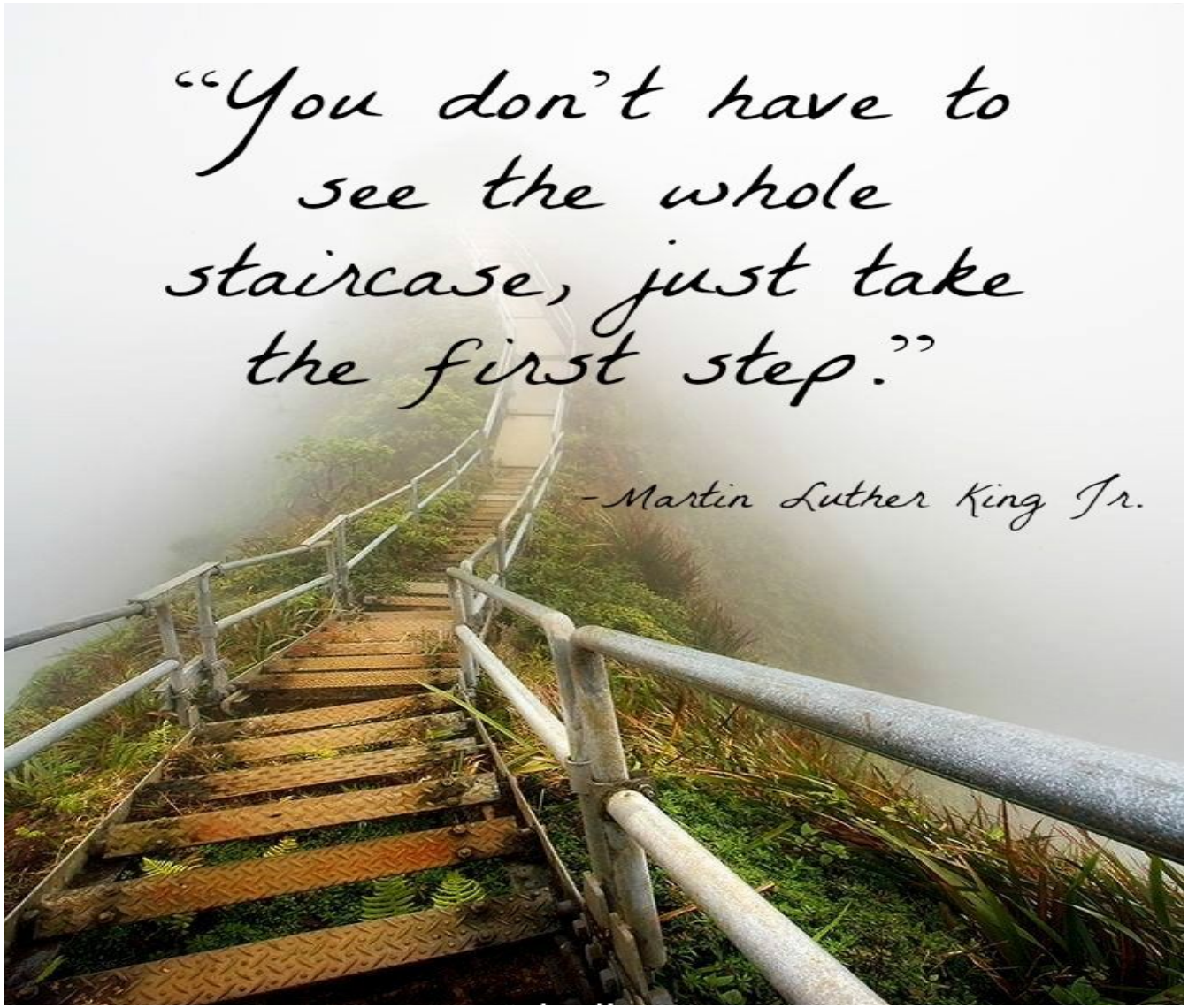
"You don't have to see the whole staircase, just take the first step."
-Martin Luther King Jr.

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Let’s begin a

conversation across distance, culture, specialties, professions, organizations, etc.

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Deepen Our Commitment to Faculty, Residents and Patients

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Think Globally

Act Locally

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The Medical Student's and Resident's Journey of Transformation

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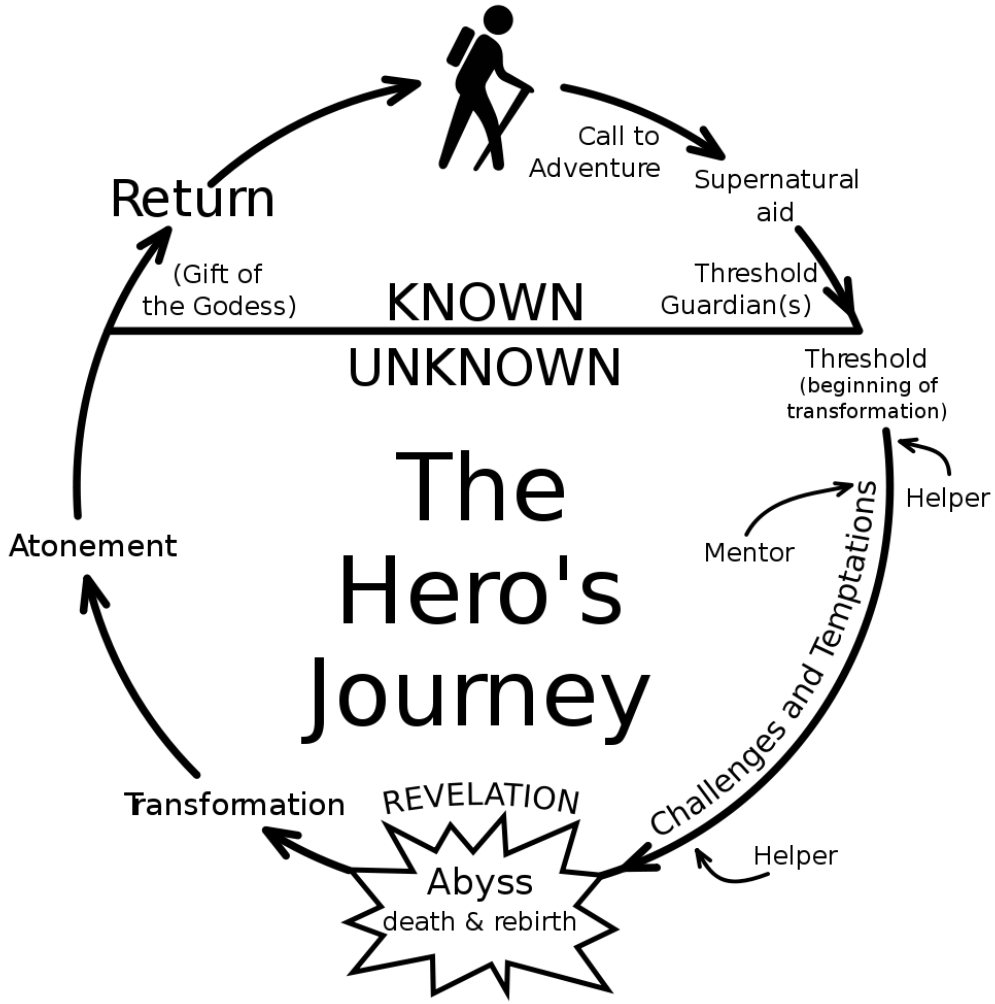
The Hero's Journey



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We're facilitating the setting of expectations…

You're working on the ground to innovate, motivate, and transform:

1. The faculty
2. The journey of the learner
3. The learning environment

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It is imperative that Program Directors, Faculty, etc., be freed and encouraged to mentor, challenge and guide

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What can you do?

How can you do it?

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$$B = f(P, E)$$

Lewin's Equation 1936

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$$WB = f(P, E)$$

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What can you do?

Realize and use your power and the power in your system

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The system in which you operate

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4 Room Apartment

Contentment 	Renewal 
Denial 	Confusion/chaos 

Claes Janssen 1982

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What to do in each room

Contentment "I like it just as it is"  Leave people alone (unless the building's on fire)	**Renewal** "We have too many good ideas"  Offer help for implementation
Denial What, me worry?"  Ask questions, give support, raise awareness	**Confusion/chaos** "What a mess!! Help!!"  Focus on the future, structure tasks, get people together

Weisbord, 1987, p. 220

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What can you do?

- Stay in touch with you
- The motivation trifecta
- Take care of yourself

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One Size Does Not Fit All

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- Who's/what's inside the white coat is more important than the white coat
- You are and each physician is human
- You are and each physician is unique
- You are and each physician is special
- You are and each physician is on a hero's journey

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- Autonomy
- Mastery
- Purpose

Daniel Pink, Drive

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Take Care of Yourself
Three Important "C"s

- Control
- Connection
  - With each other
  - Regionally/locally/nationally
  - Across specialties
  - With the larger medical (education) community
- Commitment

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Burnout at Work Isn't Just About Exhaustion. It's Also About Loneliness

by Emma Seppala and Marissa King

JUNE 29, 2017

SUMMARY SAVE SHARE 2 COMMENT TEXT SIZE PRINT $8.95 BUY COPIES

More and more people are feeling tired and lonely at work. In analyzing the General Social Survey of 2016, we found that, compared with roughly 20 years ago, people are twice as likely to report that they are always exhausted. Close to 50% of people say they are often or always exhausted due to work. This is a shockingly high statistic — and it's a 32% increase from two decades ago. What's more, there is a significant correlation between feeling lonely and work exhaustion: The more people are exhausted, the lonelier they feel.

https://hbr.org/2017/06/burnout-at-work-isnt-just-about-exhaustion-its-also-about-loneliness

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- Greater human connection at work may be one key to solving the burnout problem
- The most important factor in work happiness
  - Positive social relationships with co-workers

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The Role of Meaning

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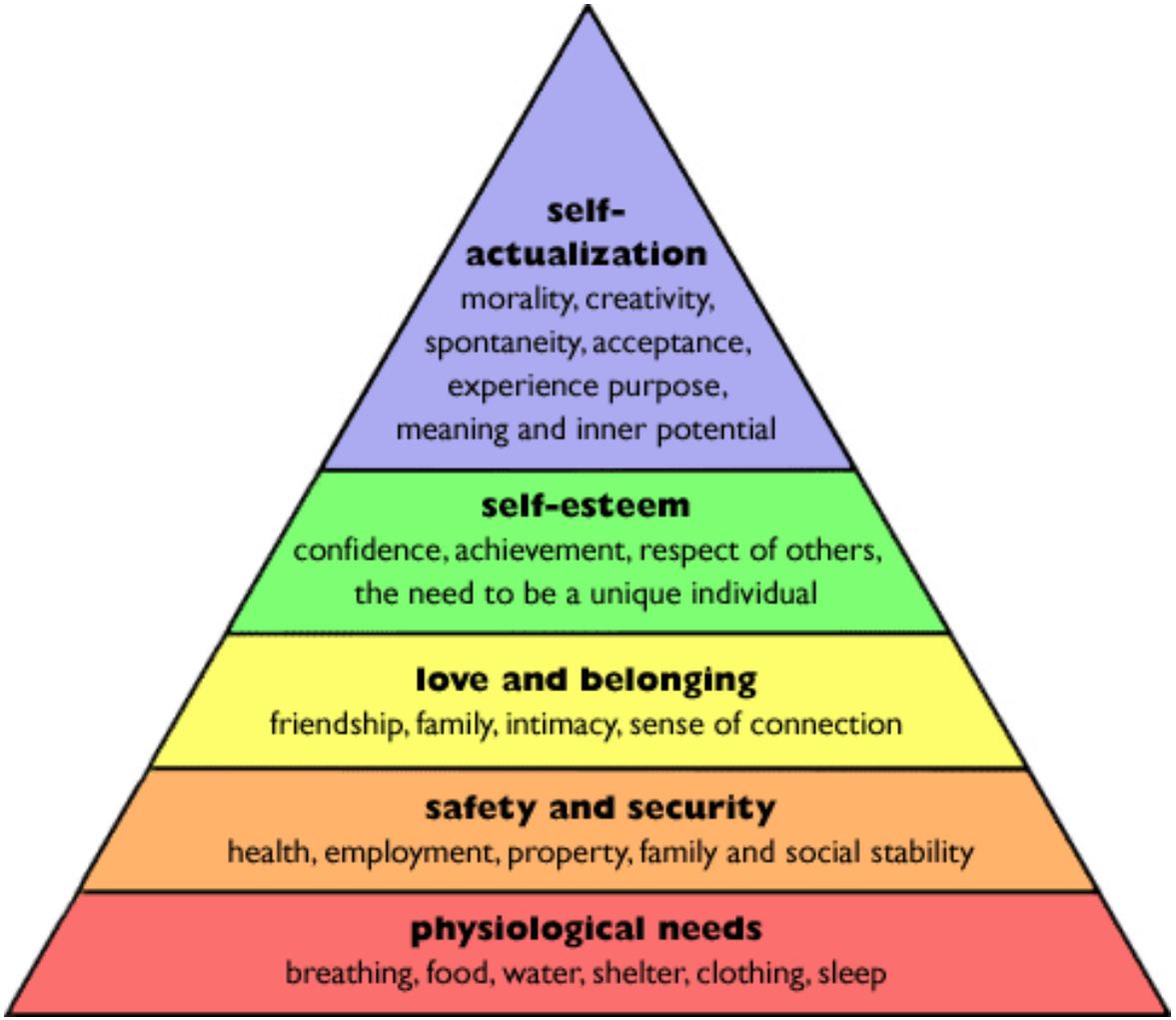
self-actualization
morality, creativity, spontaneity, acceptance, experience purpose, meaning and inner potential
self-esteem
confidence, achievement, respect of others, the need to be a unique individual
love and belonging
friendship, family, intimacy, sense of connection
safety and security
health, employment, property, family and social stability
physiological needs
breathing, food, water, shelter, clothing, sleep

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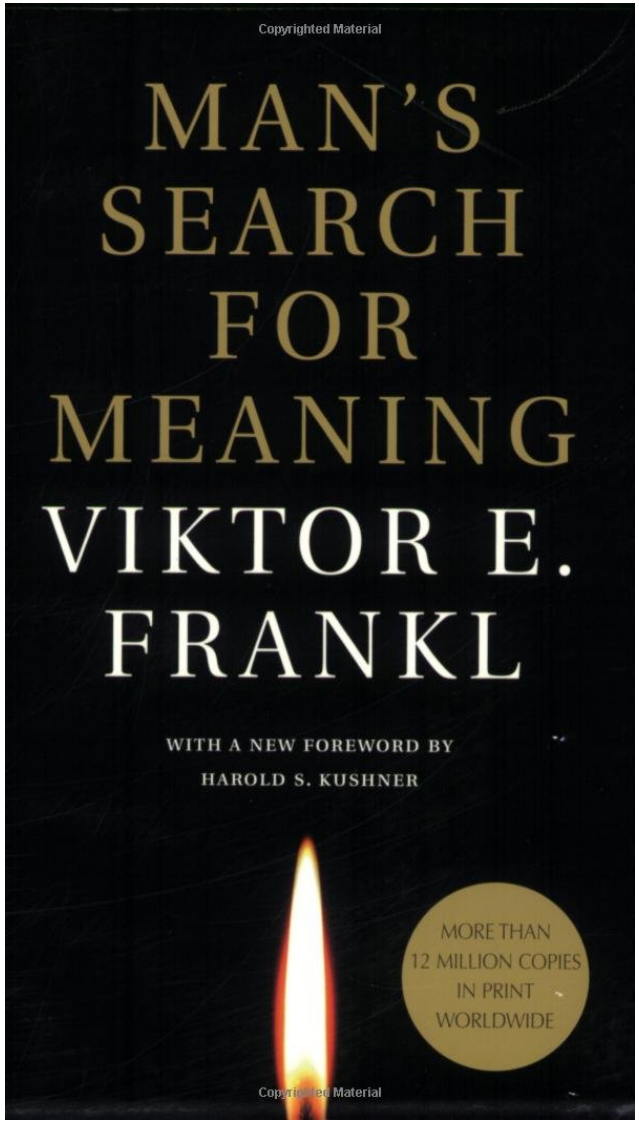
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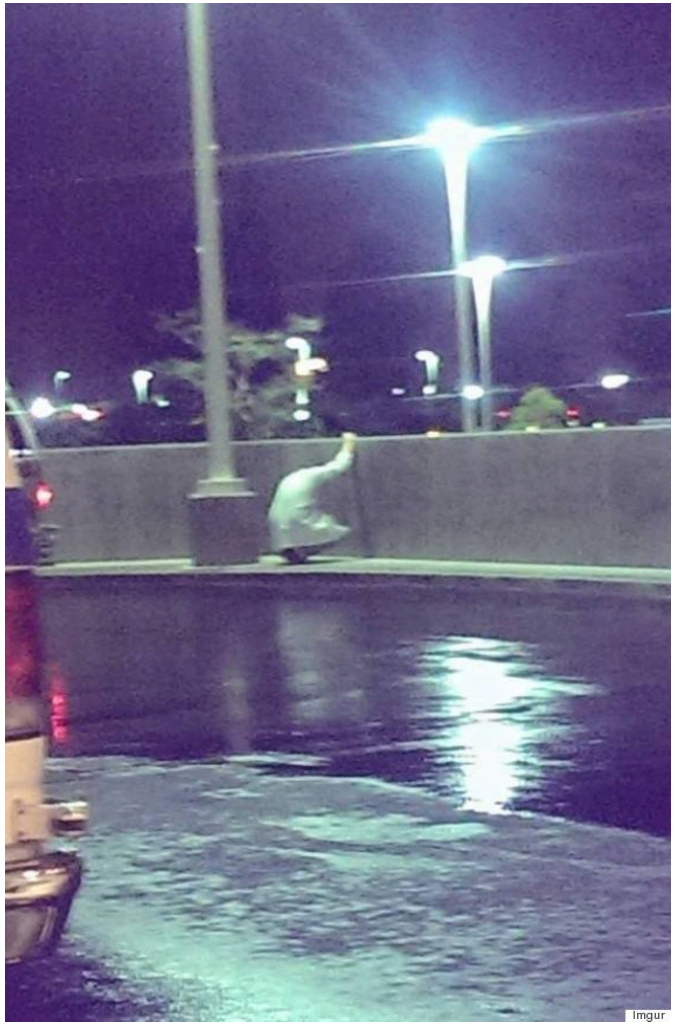

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“If you think you’re too small to be effective, you have never been in bed with a mosquito.”

Betty Reese (American officer and pilot)

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Never be afraid to try something new. Remember that amateurs built the ark, and professionals built the Titanic.

Anonymous

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LaSalle D. Leffall, MD

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Awe

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Talmud

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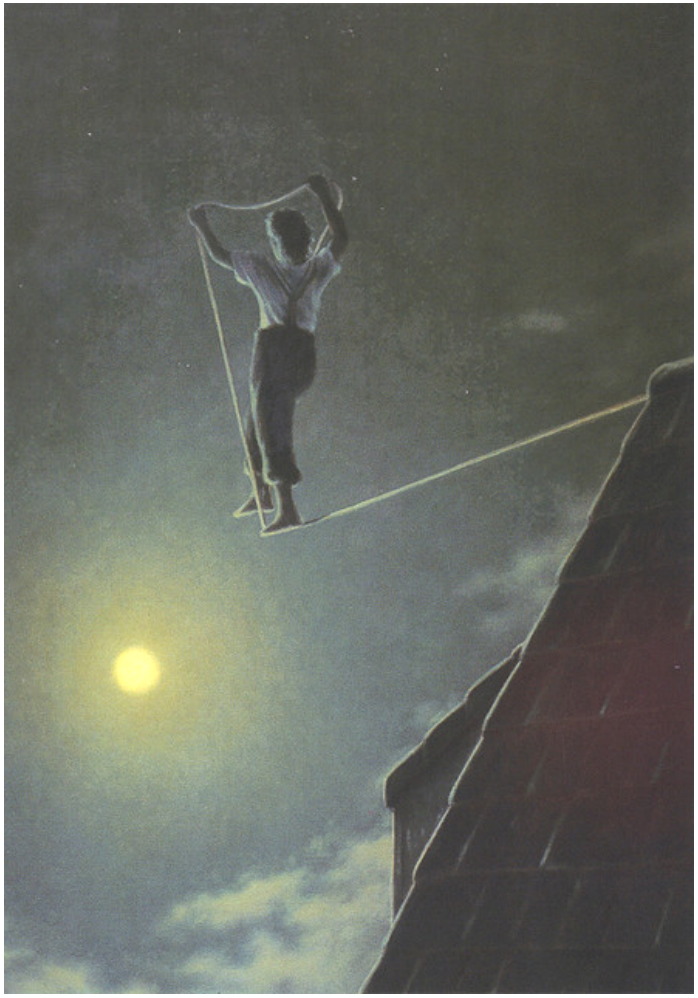

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Stay Tuned

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Thank you

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Video on Suicide Prevention

Lotte Dyrbye, MD
Christine Moutier, MD
Lyuba Konopasek, MD

Mayo Clinic and American Foundation for Suicide Prevention

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Causes of death among residents enrolled in ACGME accredited programs from 2000 through 2014

Nicholas A. Yaghmour, MPP, Timothy P. Brigham, PhD, Thomas Richter, MA, Rebecca Miller, MS, Ingrid Philibert, PhD, DeWitt C. Baldwin Jr., MD, Thomas J. Nasca, MD

T. Nasca
2017

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How do we begin to intervene to prevent suicide in Residency and Fellowship?

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